PSYCHIATRIC HOSPITAL SERVICES PAYMENT SYSTEM

*payment***basics**

Revised:
October 2009

Medicare beneficiaries with mental illnesses or alcohol- and drug-related problems may be treated in specialty inpatient psychiatric facilities (IPFs), either freestanding hospitals or specialized hospital-based units. These hospitals generally furnish short-term acute care.[1] Medicare payments to psychiatric facilities are estimated to be $4.2 billion in 2008. Medicare beneficiaries account for about 30 percent of psychiatric facilities' revenue. In 2007, 301,100 beneficiaries had 455,400 Medicare discharges from IPFs for a psychiatric or substance abuse disorder. About 1,820 facilities are Medicare certified.

To be admitted to an IPF, patients generally have to be considered a risk to themselves or others. As is the case for stays in short-term acute care hospitals, beneficiaries treated in IPFs are responsible for a deductible—$1,068 in 2009—for the first admission during a spell of illness, and for a copayment—$267 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness, with a 60-day lifetime reserve.[2] Over their lifetimes beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.

Defining the care Medicare buys

Under the prospective payment system (PPS) for IPF care, Medicare pays for the per diem routine, ancillary, and capital costs associated with furnishing covered inpatient psychiatric services. A base per diem payment is adjusted to account for differences in the cost of care related to patient characteristics (e.g., age, diagnosis, and length of stay) and facility characteristics (e.g., location and teaching status). The PPS was implemented in January 2005. Prior to that time, Medicare paid IPFs (under the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA) for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Setting the payment rates

The base payment rate for each patient day in an IPF is based on the national average daily routine operating, ancillary, and capital costs in IPFs in 2002. For rate year (RY) 2010 (beginning July 1, 2009), the base payment rate is $652 per day. The base rate is adjusted to account for patient and facility characteristics that are associated with significant cost differences (Figure 1). The patient characteristics include:

- **Age—**In general, payment increases with increasing age over 45.
- **Diagnosis—**Patients are assigned to one of 17 psychiatric Medicare-specific diagnosis related groups (MS–DRGs), such as psychosis, depressive neurosis, or personality disorders. Medicare assigns a weight to each of the MS–DRGs reflecting the average costliness of cases in that group compared with that for the most frequently reported psychiatric diagnosis in FY 2002 (MS–DRG 885, psychosis).
- **Comorbidities—**This adjustment recognizes the increased costs associated with 17 specific patient conditions—such as renal failure, diabetes, and cardiac conditions—that are secondary to the patient's principal diagnosis and that require treatment during the stay.
- **Length of stay—**Per diem payments decrease as patient length of stay increases (Table 1).

Facility-based adjustments include:

- **Wage index adjustment—**The labor-related share (76 percent) of the base per diem payment is adjusted by an

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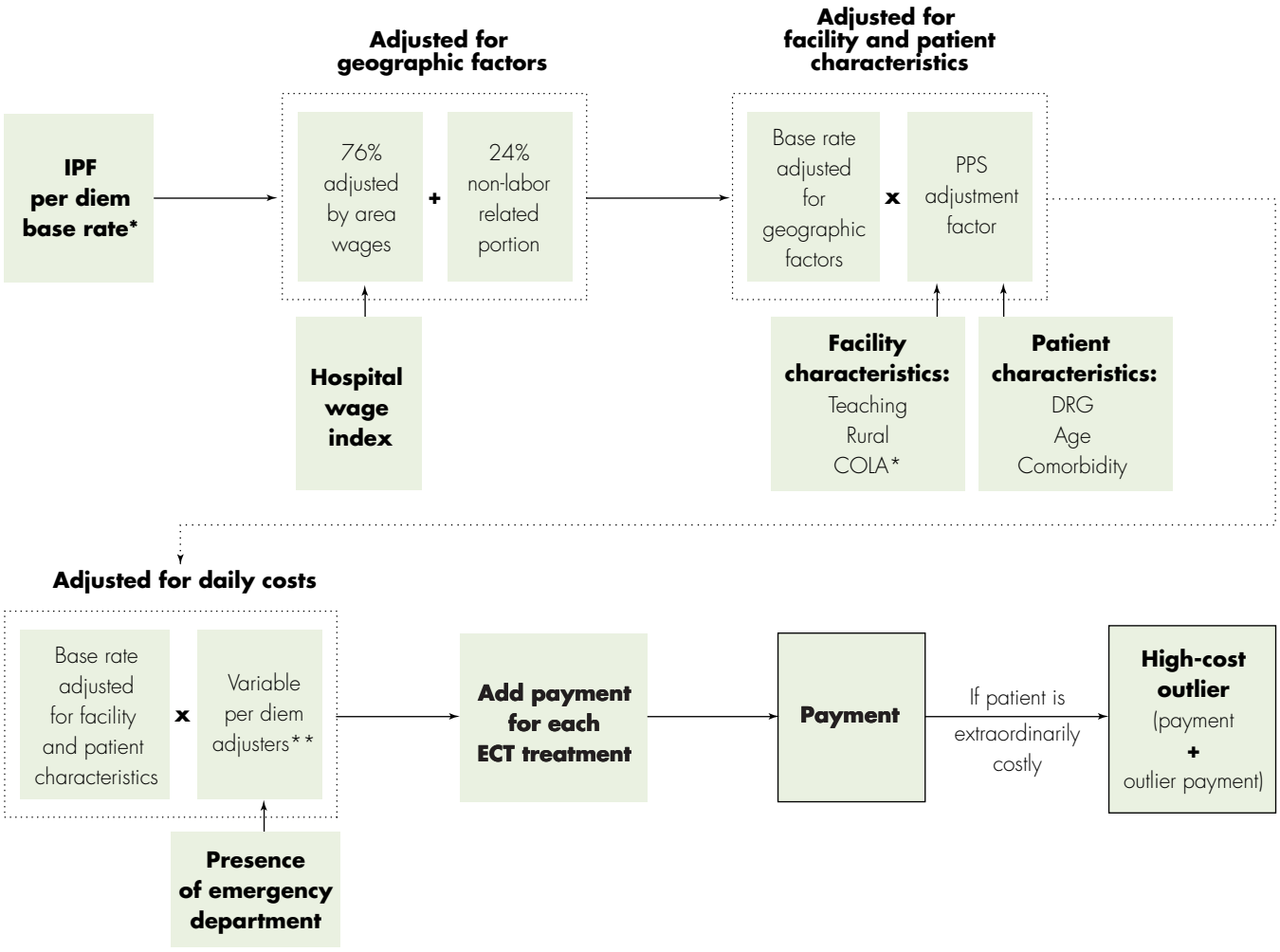
Figure 1 Psychiatric hospital services prospective payment system



Note: IPF (inpatient psychiatric facility), PPS (prospective payment system), COLA (cost of living adjustment), DRG (diagnosis related group), ECT (electro-convulsive therapy).
*A cost of living adjustment (COLA) to the non-labor related portion is made for facilities in Alaska and Hawaii.
**The variable per diem adjuster is higher for the 1st day when an emergency department is present. The adjuster declines from 1.31 with an emergency department and 1.19 without an emergency department to 0.92 over time. Table 1 shows the adjuster.

area wage index to reflect the expected differences in local market prices for labor.

- **Rural location adjustment**—IPFs in rural areas are paid 17 percent more than urban IPFs.
- **Teaching adjustment**—Teaching hospitals have an adjustment based on the ratio of interns and residents to average daily census.
- **Cost of living adjustment**—IPFs in Alaska and Hawaii are paid up to 25 percent more than IPFs located in other areas, reflecting their disproportionately higher costs.
- **Emergency department adjustment**—IPFs with qualifying emergency departments are paid 12 percent more for their patients' first day of the stay.

IPFs also receive an additional payment for each electroconvulsive therapy (ECT) treatment furnished to a patient. In RY 2009, the ECT payment is $281.

Patients who are readmitted to the IPF within three days of discharge are considered to have an interrupted stay. In such cases, Medicare treats the readmission as a continuation of

the original stay, with lengths of stay adjustments applied accordingly.

Outlier payments—The IPF PPS has an outlier policy for cases that have extraordinarily high costs, drawn from an outlier pool of 2 percent of total payments. Medicare makes outlier payments when an IPF's estimated total costs for a case exceed a threshold ($6,565 in RY 2010, adjusted for the facility characteristics outlined above) plus the total payment amount for the case. Medicare will cover 80 percent of the costs above this amount for days 1 through 9, and 60 percent of the costs above this amount for the remaining days. The different risk-sharing rates are intended to counteract the financial incentives to keep outlier cases longer than necessary.

Payment updates

There is no mechanism in law for updating payments to IPFs. CMS has stated that it intends to update the IPF payment rates annually by the increase in CMS's hospital market basket, which measures the price increases of goods and services hospitals buy to produce patient care. ■

1 Beneficiaries are also treated for psychiatric or alcohol and drug-related conditions in regular beds in acute care hospitals; in these instances providers are paid under the acute care inpatient prospective payment system (PPS).

2 The number of inpatient benefit days in the first benefit period is reduced for individuals who are in a Medicare participating IPF on their first day of entitlement to Medicare Part A. Beneficiaries are liable for a higher copayment for each lifetime reserve day—$534 per day in 2009.

Table 1 The adjusted rate for IPFs is higher for earlier days of a patient's stay

Day of patient's stay	Per diem adjustment
1 Facility:	
with a full-service emergency department	1.31
without a full-service emergency department	1.19
2	1.12
3	1.08
4	1.05
5	1.04
6	1.02
7	1.01
8	1.01
9	1.00
10	1.00
11	0.99
12	0.99
13	0.99
14	0.99
15	0.98
16	0.97
17	0.97
18	0.96
19	0.95
20	0.95
21	0.95
22 or more	0.92

Note: IPF (inpatient psychiatric facility). The per diem adjustment is applied to the base rate that is already adjusted for geographic, facility, and patient characteristics.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2009. Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2009 (RY 2010). *Federal Register* 74, no. 83 (May 1): 20381.